

COLORADO -- 2001 Nursing Facility Transitions State Grant

Identified Problems with the State's Long-Term Care System

- Financial incentive for nursing facilities to keep consumers in nursing facilities.
- No formal infrastructure to specifically focus on the issues in transitioning from nursing facilities to the community.
- Continuum of services and level of assistance varies across the state.
- No consistent means to communicate best practices throughout the state.
- No developmentally appropriate materials to increase awareness of HCBS options among nursing home consumers and to obtain informed consent from consumers.

Perceived Strengths

- Belief by the state Medicaid agency that more consumers can live in the community than are currently doing so.
- The state is well prepared for this effort due to its previous experience with the De-institutionalization project and Fast Track program, and the capacity of the Independent Living Centers (ILCs), Community Centered Boards (CCBs), and Community Mental Health centers to reach out to consumers.
- The state maintains an extensive system of home and community-based service options.

Primary Focus of Grant Activities

- Address lack of affordable and/or accessible housing.
- Inform over 1,200 individuals of their rights to live in the community.
- Transition 130 disabled consumers to community settings.
- Develop a model to use for future transition activity and/or for other states
- Establish ten support networks through Independent Living Centers to coordinate services, referrals, and follow-up.

Goals, Objectives, and Activities

Overall Goal. To create infrastructure at the state and local levels to transition consumers from nursing facilities to the community.

Goal. Build capacity across the state to reach out and support the transition of individuals in nursing facilities to a community integrated living arrangement.

Objectives/Activities

- Develop strategies to address barriers to transition, using workgroups of the State Resource Team.

- Document a comprehensive Colorado Model for Transitions, including 1) best practices, 2) sample assessments, referrals, consumer satisfaction and follow-up surveys, and 3) materials to obtain informed consent from nursing home residents for whom a written letter or form is not appropriate.

Goal. Assure that individuals who wish to make the transition have developmentally appropriate information to make the decision, and the supports necessary to sustain long-term residence and participation in the community.

Objectives/Activities

- Each ILC will establish a local support network to coordinate services, referrals, and follow-up for transition.
- Inform 1,200 disabled consumers in nursing facilities of options for community living.
- Provide case management or support coordination to transition at least 130 individuals in nursing facilities to community settings.

Key Activities and Products

- Create a State Transitions Resource Team to oversee and evaluate the project.
- Document a comprehensive Colorado Model for Transitions, including materials to use to obtain informed consent from consumers with language or literacy difficulties, or cognitive disabilities.
- Establish ten support networks to coordinate services, referrals, and follow-up for transition.
- Successfully transition 130 disabled consumers.

Consumer Partners and Consumer Involvement in Planning Activities

The Olmstead Planning Group's work formed the foundation for the proposed grant activities. Members from the Colorado Cross Disabilities Coalition, Mental Health Association, Developmental Disability Center Boards, ILCs, SEP Case Managers, and the Council on Aging also participated in proposal development.

Consumer Partners and Consumer Involvement in Implementation Activities

- The State Resource Team will include consumers, and the state will provide travel advances and expense reimbursement to people serving on the State Resource Team and its working groups.
- Project staff will provide focus groups for consumers to provide input into the development of the informed consent tool kit, and opportunities for materials review by consumers.
- Consumer satisfaction and follow-up surveys will be conducted.
- The State Resource Team will report to consumers at large through regional forums.

Public Partners

- Department of Health Care Policy and Financing.
- Department of Human Services.
- Developmental Disabilities Services.
- Mental Health Services.
- Aging and Adult Services.
- Developmental Disabilities Planning Council.
- Local housing authorities.

Private Partners and Subcontractors

Atlantis/Adapt ILC and nine other ILCs.

Public and Private Partnership Development/Involvement in the Planning Phase

Public Partners

Liaisons from Developmental Disabilities Services (DDS), Mental Health Services (MHS), Aging and Adult Services (AAS), and the Developmental Disabilities Planning Council (DDPC) participated in planning and development meetings.

Private Partners

Involvement in planning not cited.

Public and Private Partnership Development/Involvement in Implementation

Public Partners

Liaisons from Developmental Disabilities Services, Mental Health Services, Aging and Adult Services, and the Developmental Disabilities Planning Council will serve on State Resource Team working groups and participate in major decision-making.

Private Partners

- Atlantis/ADAPT ILC is the contracted implementation agency for this project. It will coordinate the activities of ten ILCs, including itself, to provide information to 1,200 consumers and transition 130 consumers to the community.
- The existing Olmstead Planning Group will continue, with added members, as part of the State Resource Team.

Existing Partnerships That Will Be Utilized to Leverage or Support Project Activities

- This grant complements the De-institutionalization Project by developing a state infrastructure to coordinate, expand, and document the process for transitions from nursing facilities in a comprehensive model for replication in other states.
- The ILCs and CCB networks have strong existing relationships with local housing authorities.

Oversight/Advisory Committee

A State Resource Team of consumers, advocates, and service providers will be created to direct, oversee, and evaluate the project.

Formative Learning and Evaluation Activities

- The Transition Project will ask three questions to determine predictable determinants for success: Does disability type affect the outcome? Does the level of need affect the outcome? Does the urban/rural/frontier location affect the outcome?
- A report designed by the State Transition Coordinator and the Project Coordinator will be completed quarterly by the 10 transition coordinators.
- Quarterly reports to HCPF.
- Monthly conference calls between the local transition coordinators.
- Quarterly meetings of the State Resource Team.

Evidence of Enduring Change/Sustainability

- State capacity to reach out and support transition will be built through the creation of a permanent State Transitions Resource Team and a lasting model for transitions.
- Emphasis will be placed on the creation of a lasting infrastructure to support transitions: 10 support networks will be established throughout the state.

Geographic Focus

Statewide.